2016 BlueChoice® HealthPlan
Tiered Prescription Drug List (PDL)

Important Information About This List

This is **not** a comprehensive list of all drugs covered under your prescription drug benefit. Not all benefit plans cover drugs listed here. To find more information about a drug *not* on this list or to verify how coverage of a certain drug applies to you, please log into My Health Toolkit® and use the Drug Coverage and Cost Tool. You can also refer to your plan materials for more information about coverage exceptions, limitations, etc.

Drug Exclusions
We cover most drugs under your pharmacy benefit. For information about excluded drugs, please see the Excluded Drug List. The list of excluded drugs is subject to change at any time. Your benefit plan may include the right for you, your doctor or another person of your choosing to request that we cover an excluded drug based on medical necessity. To begin the exception process, ask your doctor to request the formulary exception by calling Health Care Services at 800-950-5387 or faxing 800-610-5685. You (or your designated representative) may also initiate a request for a formulary exception by calling Customer Service at 800-868-2528. Additionally, your pharmacy benefit also may not cover certain categories of drugs, such as those for weight loss or drugs to treat impotence. Please check your plan materials for more details about coverage for a specific drug category.

We generally do not cover specific “lifestyle” medications under the pharmacy benefit. Some examples of these types of drugs include those for:

- The treatment of hair loss
- Sexual dysfunction
- Weight loss
- Skin pigmentation treatments

Members can get these types of drugs at a discounted price by presenting their prescription and member ID cards at network pharmacies. Since some plans may cover one or more of these drug categories, check your plan materials for more information.

Copayments

The 2016 ***Tiered PDL*** covers drugs that treat all medical conditions.[1] Each tier represents a different copayment (or coinsurance) level. We assign drugs to a tier based on how well they work (effectiveness) and how much they cost compared to other drugs that treat the same or similar conditions (value). Look at your benefit plan documents to find out how much you will pay when you fill a prescription.

This chart is an overview of the drug tiers your plan covers. Drugs on the lowest tiers will cost you the least amount of money.[2]

Member Cost	Drug Tier	Usually Includes
$	Tier 1	Lowest-cost prescription generic and some over-the-counter drugs
$$	Tier 2	Prescription generic and some over-the-counter drugs
$$$	Tier 3	Brand-name drugs that don’t have a generic available. Also may include higher-priced generics that have more cost-effective options at lower tiers.

$$$$	Tier 4	Brand-name drugs that have brand or generic options at lower tiers. Also may include higher-priced generics that have more cost-effective options at lower tiers.
$$$$$	Tier 5	Specialty drugs[3] that are more cost-effective than other specialty drugs that treat the same conditions. Also may include some non-specialty brand or generic drugs that have more cost-effective options at lower tiers.
$$$$$$	Tier 6	Specialty drugs that have more cost-effective alternatives at Tier 5. Also, may include some non-specialty brand or generic drugs that have more cost-effective options at lower tiers.

[1]The exception to this is any drug or category specifically excluded by the member's contract.

[2] The Affordable Care Act (ACA) requires we cover certain drugs at $0 for most members. These drugs do not have a tier. Also, if you have a high deductible plan, these tier categories will apply until you reach your deductible. Check your Schedule of Benefits.

[3] Specialty drugs are prescription medications that are used to treat complex or chronic medical conditions like cancer, rheumatoid arthritis, multiple sclerosis and hepatitis C.

The BlueChoice® Pharmacy and Therapeutics (P & T) committee includes independent physicians and pharmacists who advise BlueChoice on pharmacy decisions, including tier placement.

Quantity Limitations

The P & T committee sets maximum-allowed amounts for certain prescription drugs. It bases the amounts on U.S. Food and Drug Administration (FDA) prescribing guidelines and available package sizes. As a result, we limit coverage for some drugs to a certain quantity within a certain period of time. In this drug list, you will see "QL" next to drugs with quantity limits. Unless otherwise noted, one month equals a 31-day supply.

Prior Authorization

Doctors must get prior authorization for certain drugs. This helps make sure the drugs are used according to their product labeling. We base the need for prior authorization on current FDA guidelines. We also base it on clinical decisions from the BlueChoice P & T committee. Before a doctor prescribes a prior authorization drug, he or she should call Caremark at 800-294-5979. In this drug list, you will see "PA" next to drugs that require prior authorization. Caremark is an independent company that administers prescription drug benefits on behalf of BlueChoice.

Medical Necessity Prior Authorization

We will not cover some medications without prior authorization for medical necessity (MN). Before a doctor prescribes an MN prior authorization drug, he or she should call Caremark at 800-294-5979. In this drug list, you will see "MN" next to drugs that require medical necessity prior authorization.

Step Therapy

Some drugs require members to satisfy certain step therapy criteria before they can get the drug. Before a doctor prescribes a step therapy drug, he or she should call BlueChoice at 800-950-5387. We will decide if we can approve the drug based on the step therapy criteria for that drug. In this drug list, you will see "ST" next to

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

drugs that have a step therapy requirement. Unless otherwise noted, the requirement only applies to brand medications, not the generic version if there is one available.

Specialty Pharmaceuticals
Specialty pharmaceuticals are drugs that treat complex or chronic medical conditions and that are usually very expensive. We cover some of these drugs under the pharmacy benefit (oral and self-injectable drugs) and we cover others under the medical benefit. You will see some specialty drugs included on this list. For information about specialty drugs, please see the **Specialty Drug** list.

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ABILIFY	4	aripiprazole	1	ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone or Seroquel XR in the last 365 days
ABSTRAL	4			PA, QL. QL is 120 doses per month.	Coverage provided for members 18 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain
ACCOLATE	4	zafirlukast	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ACCU-CHEK kits and test strips	4			MN	Alternatives that do not require PA for medical necessity are OneTouch products
ACCUPRIL	4	quinapril	1		
ACCURETIC	4	quinapril/-HCT	1		
acetazolamide			1		
ACIPHEX	4	rabeprazole	1	ST, QL	Requires step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing.
ACTEMRA	6			MN	See specialty drug list for further information.
ACTICLATE	5			PA	Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review.
ACTIGALL	4	ursodiol	1		
ACTIQ	4	fentanyl transmucosal	1	PA, QL. QL is 120 doses per month.	Coverage provided for members 16 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain. PA is required for both brand and generic.
ACTIVELLA	4	estradiol/ norethindrone acetate	1		
ACTONEL (daily dose)	4	risedronate	1	QL	QL of 31 tabs per month
ACTONEL (weekly dose)	4	risedronate	1	QL	QL of 4 tabs per month

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ACTONEL 150 mg (monthly dose)	4	risedronate	1	QL	QL of 1 tab per month or 3 tabs per 3 months
ACTOPLUS MET	4	pioglitazone-metformin	1		
ACTOPLUS MET XR	4				
ACTOS	4	pioglitazone	1		
ACULAR	4	ketorolac ophthalmic	1		
ADALAT CC	4	nifedipine ext-rel	1		
ADDERALL	4	dextroamphetamine/ amphetamine	1	QL	Quantity Limits: 5mg-10mg: 90 per month 15mg-20mg: 60 per month 30mg: 60 per month
ADDERALL XR	4	dextroamphetamine/ amphetamine ext-rel	1	QL	QL of 30 caps per month
ADEMPAS	5			PA	See specialty drug list for further information.
ADOXA	4	doxycycline monohydrate	1	PA	Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review.
ADVAIR DISKUS	3			QL	QL of 1 inhaler per month
ADVAIR HFA	3			QL	QL of 1 inhaler per month
ADVICOR	4			MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, Simcor
ALAVERT OTC	1	loratadine	1		OTC preparation available at Tier 1 copayment with prescription
ALAVERT-D OTC	1	loratadine/ pseudoephedrine	1		OTC preparation available at Tier 1 copayment with prescription
albuterol inhalation solution, syrup, tabs			1	QL	

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ALDACTAZIDE	4	spironolactone/ HCTZ	1		
ALDACTONE	4	spironolactone	1		
ALLEGRA OTC	1	fexofenadine	1		OTC preparation available at Tier 1 copayment with prescription
ALLEGRA-D OTC	1	fexofenadine/ pseudoephedrine	1		OTC preparation available at Tier 1 copayment with prescription
ALPHAGAN P 0.1%	3				
ALTACE	4	ramipril	1		
ALTOPREV	4			MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin
ALVESCO	3			QL	QL of 2 inhalers per month at retail or 6 units per 3 months by mail order
amantadine			1		
AMARYL	4	glimepiride	1		
AMBIEN	4	zolpidem	1	MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 tabs per month at retail or 93 per 3 months by mail order.
AMBIEN CR	4	zolpidem ext-rel	1	MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order.
AMERGE	4	naratriptan	1	QL	QL of 8 tabs per month, all strengths. Additional quantities require PA.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
amiloride/ hydrochlorothiazide			1		
AMITIZA	4			MN	Alternative that does not require PA for medical necessity is Linzess.
amitriptyline			1		
AMNESTEEM			3		
amoxicillin			1		
ampicillin			1		
AMPYRA	5			PA	See specialty drug list for further information.
AMRIX	5			MN	Alternative that does not require PA for medical necessity is cyclobenzaprine
ANADROL-50	4			PA	Coverage provided for treatment of anemias caused by deficient red blood cell production.
ANAFRANIL	4	clomipramine	1		
ANAPROX	4	naproxen sodium	1		
ANDRODERM	3			PA	Coverage provided for male members who need replacement therapy in conditions associated with deficiency or absence of endogenous testosterone
ANDROGEL	4	testosterone gel	1	MN	If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options. PA is required for both brand and generic formulations.
ANORO ELLIPTA	3			QL	QL of 1 inhaler per month

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ANTARA	4	fenofibrate micronized	1	ST	Coverage requires a 30-day trial of a generic fenofibrate before a non-preferred brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix)
ANTIVERT	4	meclizine	1		
ANUSOL HC	4	hydrocortisone acetate topical	1		
APIDRA	4			MN	Alternatives that do not require PA for medical necessity are Novolin, Novolog
APRISO	3				
APTENSIO XR	4			QL	Quantity Limit: 10mg-30mg; 60 per month 40mg-60mg: 30 per month
APTIVUS	3				
ARALEN	4	chloroquine phosphate	1		
ARANESP	6			PA	See specialty drug list for further information.
ARTHROTEC	4	diclofenac sodium/misoprostol	1		
ASACOL HD	3				
ASMANEX	3			QL	QL varies by strength. Retail: Asmanex 7 – 2 inhalers; Asmanex 14 – 4 inhalers; Asmanex 30 – 2 inhalers (220mcg/inhaler) or Asmanex 30 – 1 inhaler (110mcg/inhaler); Asmanex 60 – 1 inhaler; Asmanex 120 – 1 inhaler at retail. Multiply each strength by 3 for mail order.
ASTEPRO	4	azelastine nasal	1	QL	QL of 1 inhaler per month at retail or 3 inhalers per 3 months by mail order

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ATACAND	4	candesartan	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
ATACAND HCT	4	candesartan/HCTZ	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
ATIVAN	4	lorazepam	1		
ATRIPLA	3				
ATROVENT INHAL SOLN	4	ipratropium bromide	1		
ATROVENT HFA	3			QL	QL of 2 inhalers per month
ATROVENT NASAL	4	ipratropium bromide nasal	1	QL	
AUBAGIO	6			MN	See specialty drug list for further information.
AUGMENTIN	4	amoxicillin/ clavulanate	1		
AUGMENTIN XR	4	amoxicillin/ clavulanate	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
AVALIDE	4	irbesartan/HCTZ	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
AVAPRO	4	irbesartan	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
AVELOX	4	moxifloxacin	1		
AVONEX	6			MN	See specialty drug list for further information.
AXERT	5	almotriptan	1	QL	QL of 8 tabs per month, all strengths. Additional quantities require PA.
AXID	4	nizatidine	1		
AXIRON	3			PA	Coverage provided for male members who need replacement therapy in conditions associated with deficiency or absence of endogenous testosterone
azelastine nasal spray			1	QL	QL 1 inhaler per month at retail or 3 inhalers per 3 months by mail order
AZOPT	3				
AZOR	3				
AZULFIDINE	4	sulfasalazine	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
bacitracin ophthalmic ointment			1		
baclofen			1		
BACTROBAN	4	mupirocin topical	1		
BACTROBAN NASAL	4				
BANZEL	3				
BARACLUDE	4	entecavir	1		
BECONASE AQ	4			MN, QL	Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 2 inhalers per month at retail or 6 inhalers per 3 months by mail order
BELSOMRA	5			MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order.
BENICAR	3				
BENICAR HCT	3				
BENTYL	4	dicyclomine	1		
benztropine			1		
BETAGAN	4	levobunolol ophthalmic	1		
betamethasone dipropionate crm, gel, lotion, oint 0.05%			1		
BETAPACE	4	sotalol	1		
BETAPACE AF	4	sotalol	1		
BETASERON	5			PA	See specialty drug list for further information.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
BETIMOL	4				
BIAXIN	4	clarithromycin	1		
BIAXIN XL	4	clarithromycin	1		
bimatoprost 0.03%			1		
BLEPH-10	4	sulfacetamide ophthalmic	1		
BLEPHAMIDE SOP	3				
BONIVA 150 mg TABS	4	ibandronate	1	QL	QL of 1 tab per month
BRAVELLE	6			MN	See specialty drug list for further information.
BREO ELLIPTA	3			QL	QL of 1 inhaler per month
BREVICON	4	norethindrone/ ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
brimonidine 0.15%, 0.2%			1		
BUNAVAIL	4			MN, QL	Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program. Alternatives that do not require PA for medical necessity are generic buprenorphine-naloxone sublingual tablets and Suboxone film.
buprenorphine			1	PA, QL	Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
buprenorphine/ naloxone sublingual tabs			1	PA, QL	Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program
bupropion 150mg extended release			$0	PA, QL	Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials Limit of 30-day supply for each prescription; maximum therapy of 180 days per each 365 period.
buspirone			1		
BUTRANS	4			QL	QL of 4 patches per month
butorphanol nasal spray			1	PA, QL	QL of 2 units per month. Additional quantities require PA.
BYDUREON	3				
BYETTA	4			MN	Alternatives that do not require PA for medical necessity are Bydureon, Victoza
BYSTOLIC	3				
CAFERGOT	4				
CALAN	4	verapamil	1		
CALAN SR	4	verapamil ext-rel	1		
CAMBIA	4			QL	QL of 4 packets per month
CANASA SUPPOSITORY	3				
captopril			1		
CARAFATE	4	sucralfate	1		
CARDIZEM CD	4	diltiazem ext-rel	1		
CARDIZEM LA	4	diltiazem ext-rel	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
CARDURA	4	doxazosin	1		
CATAPRES	4	clonidine	1		
CAYSTON, inhalation	6			PA	See specialty drug list for further information.
cefdinir			1		
CEFTIN	4	cefuroxime	1		
cefprozil			1		
CELEBREX	4	celecoxib	1	ST, QL, PA	Requires step thru generic DMARDs, NSAIDs, or GI drugs. QL of 62 of 100 mg or 31 of 200 mg per month. PA required for doses > 200 mg daily. ST and PA are required for both brand and generic formulations.
CELEXA	4	citalopram	1		
CELLCEPT	6	mycophenolate mofetil	2		
cetirizine OTC			1		OTC preparation available at Tier 1 copayment with prescription for OTC formulation
cetirizine-D OTC			1		OTC preparation available at Tier 1 copayment with prescription for OTC formulation
CHANTIX	$0			PA, QL	Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials Limit of 30-day supply for each prescription; maximum therapy of 180 days per each 365 period.
chlorthalidone			1		
CIALIS	4			See limitations	Check member drug benefit for coverage of oral erectile dysfunction drugs

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ciclopirox			1		
cimetidine			1		
CIMZIA	6			MN	See specialty drug list for further information.
CIPRO HC OTIC	3				
CIPRO	4	ciprofloxacin	1		
ciprofloxacin ext-rel tabs			1		
CITRANATAL VITAMINS	3				
CLARINEX	4	desloratadine	1	ST	Requires 21-day trial of OTC non-sedating/mildly sedating antihistamine in the last 12 months
CLARINEX D	4	desloratadine/ pseudoephedrine	1	ST	Requires 21-day trial of OTC non-sedating/mildly sedating antihistamine in the last 12 months
CLARITIN OTC	1	loratadine	1		OTC preparation available at Tier 1 copayment with prescription
CLARITIN-D OTC	1	loratadine/ pseudoephedrine	1		OTC preparation available at Tier 1 copayment with prescription
CLARAVIS			3		
CLEOCIN	4	clindamycin	1		
CLEOCIN VAG SUPP	4				
CLEOCIN T	4	clindamycin topical	1		
CLIMARA	4	estradiol transdermal	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
CLOZARIL	4	clozapine	1	ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days
COLAZAL	4	balsalazide	1		
COLCRYS	5	colchicine	1	QL	QL of 60 tabs per month
COLOCORT			1		
COMBIGAN	3				
COMBIVENT RESPIMAT	3			QL	QL of 2 inhalers per month
COMBIVIR	4	lamivudine/ zidovudine	1		
COMPLERA	3				
COMTAN	4	entacapone	1		
CONCERTA	4	methylphenidate ext-rel	1	QL	Quantity Limit: 18mg-36mg: 60 per month 54mg: 30 per month
CONDYLOX GEL	4				
CONDYLOX SOLN	4	podofilox	1		
COPAXONE	5	glatopa	5	PA	See specialty drug list for further information.
COPEGUS	6	ribavirin	6		
CORDARONE	4	amiodarone	1		
COREG	4	carvedilol	1		
CORGARD	4	nadolol	1		
CORTEF	4	hydrocortisone	1		
CORTIFOAM	3				

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
CORTISPORIN OTIC	4	neomycin/ polymyxin B/hydrocortisone otic	1		
COSENTYX	6			MN	See specialty drug list for further information.
COSOPT	4	dorzolamide/timolol ophthalmic	1		
COUMADIN	4	warfarin	1		
COZAAR	4	losartan	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
CREON	3				
CRESTOR	4			MN	Alternative that does not require PA for medical necessity is atorvastatin
CRIXIVAN	3				
cromolyn inhalation, ophthalmic			1		
CYCLESSA	4	desogestrel/ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
cyclobenzaprine			1		
cyclosporine			2		
CYMBALTA	4	duloxetine	1	ST, QL	Requires 30-day trial of generic SSRI/SNRI in last 180 days. QL of 62 per month for 20 mg, 31 per month for 30 mg, 62 per month for 60 mg.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
cyproheptadine			1		
CYTOTEC	4	misoprostol	1		
DANTRIUM	4	dantrolene	1		
dapsone			1		
DAYPRO	4	oxaprozin	1		
DDAVP SPRAY	4	desmopressin nasal	1	QL	QL of 2 bottles per month
DELZICOL	5				
DEMADEX	4	torsemide	1		
demeclocycline			1		
DENAVIR	4			QL	QL of 1 – 5gm tube per month
DEPAKENE	4	valproic acid	1		
DEPAKOTE	4	divalproex sodium	1		
DEPAKOTE ER	4	divalproex sodium ext-rel	1		
DEPAKOTE SPRINKLES	4	divalproex sodium	1		
DESOGEN	4	desogestrel/ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
DESVENLAFAXINE ER	4			ST, QL	Requires 30-day trial of generic SNRI in last 180 days. QL of 31 per month.
DETROL	4	tolterodine	1	MN	Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext -rel, trospium, trospium ext-rel, Gelnique, Vesicare
DETROL LA	4	tolterodine ext-rel	1	MN	Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext- rel, trospium, trospium ext-rel, Gelnique, Vesicare

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
dexamethasone			1		
dexamethasone sodium phosphate			1		
DEXEDRINE	4	dextroamphetamine ext-rel	1	QL	Quantity Limit: 5mg-10mg: 90 per month 15mg:60 per month
dextroamphetamine			1	QL	Quantity Limit: 2.5mg-10mg: 90 per month 15mg-20mg: 60 per month 30mg: 30 per month
DEXILANT	4			ST, QL	Requires step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing.
diclofenac sodium delayed-rel tabs			1		
diclofenac sodium ophthalmic			1		
dicloxacillin			1		
DIFLUCAN TABS	4	fluconazole	1		
DILANTIN 100 mg CAPS	4	phenytoin	1		
DILANTIN 125/5 SUSP	4	phenytoin	1		
DILANTIN 30 mg CAPS	3				
DILANTIN 50 mg CHEW	4	phenytoin	1		
DILAUDID	4	hydromorphone	1	QL	QL of 180 tabs per month at retail

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
DIOVAN	4	valsartan	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
DIOVAN HCT	4	valsartan-HCT	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
diphenhydramine			1		
DITROPAN XL	4	oxybutynin ext-rel	1	MN	Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel, trospium, trospium ext-rel, Gelnique, Vesicare
DONNATAL	5				
DORYX	5			PA	Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review.
DOVONEX	4	calcipotriene topical	1		
doxepin			1		
DUAC	4	clindamycin/benzoyl peroxide topical	3		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
DULERA	4			MN, QL	Alternatives that do not require PA for medical necessity are Advair, Advair HFA, Symbicort. QL of 1 inhaler per month
DURAGESIC	4	fentanyl transdermal	1	QL	QL of 10 patches per month. Additional quantities require PA.
DUREZOL	3				
DYANAVEL XR	4			QL	QL of 240 mL per month
DYAZIDE	4	triamterene/ hydrochlorothiazide	1		
DYMISTA	4			MN, QL	Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month at retail or 3 inhalers per 3 months by mail order
EDARBI	4			MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
EDARBYCLOR	4			MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
EDLUAR	4			MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order.
EDURANT	3				
E.E.S.	4	erythromycin ethylsuccinate	1		
EFFEXOR XR	4	venlafaxine ext-rel	3	QL	QL of 31 per month for 37.5 mg, 75 mg XR, or 150 mg XR.
EFUDEX	4	fluorouracil topical	1		
ELIDEL CREAM	3				Coverage for 2 years of age and up. If less than 2 years old, call BlueChoice at 800-950-5387.
ELIQUIS	3				
ELLA	$0				Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
EMEND 40 mg	4			QL, PA	QL of 4 of 40 mg per month. Additional quantities require PA.
EMEND 80 mg, 125 mg	4			QL, PA	QL of 2 of 80 mg or 125 mg per month. Additional quantities require PA.
EMTRIVA	3				
ENBREL	5			PA	See specialty drug list for further information.
ENJUVIA	3				
ENTYVIO	6			MN	See specialty drug list for further information.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
EPANOVA	4			PA	Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA-approved therapy to lower triglycerides along with diet
EPIPEN	3				
EPIPEN JR.	3				
EPIVIR TABS	4	lamivudine	1		
EPIVIR SOLUTION	4	lamivudine	1		
EPOGEN	6			PA	See specialty drug list for further information.
EPZICOM	3				
ERY-TAB			1		
erythromycin			1		
erythromycin stearate			1		
ESTRACE TABS	4	estradiol	1		
ESTRING	4				Packaged as 90-day supply for two times the applicable copayment
etodolac			1		
etoposide			1		
EUFLEXXA	6			MN	See specialty drug list for further information.
EVEKEO	4			PA, QL	Coverage provided for ADHD or narcolepsy after trial of 2 generic amphetamine products. QL of 60 per month.
EVISTA	4	raloxifene	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
EXALGO	5	hydromorphone ext-rel	4	QL	Coverage provided for treatment of opioid-tolerant patients who require continuous, around-the-clock analgesia for an extended timeframe. QL applies based on dosing. PA is required for both brand and generic formulations.
EXELON CAPS	4	rivastigmine	1		
EXFORGE	3	amlodipine/ valsartan	1		
EXFORGE HCT	3	amlodipine/ valsartan/HCT	1		
EXTAVIA	6			MN	See specialty drug list for further information.
FABIOR	4			ST	Requires 30-day trial of generic tretinoin product in the last 365 days
FAMVIR	4	famciclovir	1		
FANAPT	4			ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone ziprasidone or Seroquel XR in the last 365 days
FARXIGA	3				
FAZACLO	4	clozapine orally disintegrating tabs	1	ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone ziprasidone or Seroquel XR in the last 365 days
FELDENE	4	piroxicam	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
FEMHRT 0.5/2.5	4	norethindrone acetate/ethinyl estradiol	1		
FEMRING	3				Packaged as 90-day supply for 2 times the applicable copayment
FENOGLIDE	4	fenofibrate	1	ST	Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix)
FENTORA	4			PA, QL QL is 120 doses per month.	Coverage provided for members 16 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain
FETZIMA	4			ST, QL	Requires 30-day trial of generic SNRI in last 180 days. QL of 31 per month.
fexofenadine OTC			1		OTC preparation available at Tier 1 copayment with prescription for OTC formulation
fexofenadine-D OTC			1		OTC preparation available at Tier 1 copayment with prescription for OTC formulation
FIBRICOR	4	fenofibric acid	1	ST	Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix)

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
finasteride 5 mg			1	PA	Coverage provided for the treatment of symptomatic benign prostatic hypertrophy in males over age 40. PA is required for both brand and generic formulations.
FIORICET	4	butalbital/ acetaminophen/ caffeine	1		
FIORINAL	4	butalbital/aspirin/ caffeine	1		
FIRST-LANSOPRAZOLE	4			ST, QL	Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing.
FIRST-OMEPRAZOLE	4			ST, QL	Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing.
FLAGYL	4	metronidazole	1		
FLAGYL ER	4				
fludrocortisone			1		
FLOMAX	4	tamsulosin	1		
FLOVENT DISKUS	3			QL	QL of 1 inhaler per month
FLOVENT HFA	3			QL	QL of 2 inhalers per month
flunisolide nasal			1	QL	QL of 1 inhaler per month
fluocinonide crm, gel, oint, soln 0.05%			1		
FLUOROPLEX	3				
fluphenazine			1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
fluticasone propionate nasal			1	QL	QL of 1 inhaler per month.
FML OPHTH DROP	4	fluorometholone ophthalmic	1		
FOCALIN	4	dexmethylphenidate	1	QL	QL of 60 per month
FOCALIN XR	4	dexmethylphenidate ext-rel	1	QL	Quantity Limit: 5mg-20mg: 60 per month 25mg-40mg: 30 per month
FOLLISTIM AQ	6			MN	See specialty drug list for further information.
FORTAMET	4			MN	Alternatives that do not require PA for medical necessity are metformin, metformin ext-rel
FORTEO	5			PA	See specialty drug list for further information.
FORTESTA	4	testosterone gel	1	MN	If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options. PA is required for both brand and generic formulations.
FOSAMAX (daily dose)	4	alendronate	1	QL	QL of 31 tabs per month
FOSAMAX (weekly dose)	4	alendronate	1	QL	QL of 4 tabs per month
FOSAMAX PLUS D (weekly dose)	4			QL	QL of 4 tabs per month
FROVA	4			QL	QL of 8 tabs per month. Additional quantities require PA.
GELNIQUE	3				
GEL-ONE	5			PA	See specialty drug list for further information.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
GENGRAF	6	cyclosporine, modified	2		
GENOTROPIN	6			MN	See specialty drug list for further information.
gentamicin ophthalmic, topical			1		
GEODON	4	ziprasidone	1	ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone ziprasidone or Seroquel XR in the last 365 days
GIANVI			1		
GILENYA	5			PA	See specialty drug list for further information.
GLEEVEC	6	imatinib	2	PA	See specialty drug list for further information.
GLUCAGON	3				
GLUCOPHAGE	4	metformin	1		
GLUCOPHAGE XR	4	metformin ext-rel	1		
GLUCOTROL	4	glipizide	1		
GLUCOTROL XL	4	glipizide ext-rel	1		
GLUCOVANCE	4	glyburide/metformin	1		
GLUMETZA	4	metformin ext-rel	1	MN	Brand and generic require MN PA. Alternatives that do not require PA for medical necessity are metformin, metformin ext-rel
GOLYTELY	4	polyethylene glycol/electrolytes	1		
GONAL-F	5			PA	See specialty drug list for further information.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
GRALISE	4			PA	Coverage requires that members have tried at least a 30-day supply of gabapentin immediate-release at a dose of 1800 mg daily without adequate response
granisetron tabs			1	QL, PA	QL of 4 tabs per month. Additional quantities require PA.
GRIS-PEG	4	griseofulvin ultramicrosize	1		
haloperidol			1		
HUMALOG (ALL FORMS)	4			MN	Alternatives that do not require PA for medical necessity are Novolin, Novolog
HUMATROPE	5			PA	See specialty drug list for further information.
HUMIRA	5			PA	See specialty drug list for further information.
HUMULIN (ALL FORMS except R U-500)	4			MN	Alternatives that do not require PA for medical necessity are Novolin, Novolog
HUMULIN R U-500	3				
HYALGAN	5			PA	See specialty drug list for further information.
hydralazine			1		
HYDREA	4	hydroxyurea	1		
hydrochlorothiazide			1		
hydrocortisone crm 2.5%			1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
HYZAAR	4	losartan-HCT	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
IMITREX INJECTION	4	sumatriptan	1	QL	QL of 3 kits or 5 vials per month. Additional quantities require PA.
IMITREX NASAL	4	sumatriptan	1	QL	QL of 3 boxes (20 mg) or (5 mg) per month. Additional quantities require PA.
IMITREX TABS	4	sumatriptan	1	QL	QL of 8 tabs per month, all strengths. Additional quantities require PA.
IMURAN	6	azathioprine	2		
INDERAL LA	4	propranolol ext-rel	1		
INTELENCE	3				
INTERMEZZO	4			MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order.
INVEGA	4	paliperidone ext-rel	1	ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days
INVIRASE	3				

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
INVOKAMET	4			MN	Alternatives that do not require PA for medical necessity are Farxiga, Jardiance, Synjardy, and Xigduo XR
INVOKANA	4			MN	Alternatives that do not require PA for medical necessity are Farxiga, Jardiance, Synjardy, and Xigduo XR
ipratropium/albuterol inhalation			1		
IRENKA	4			ST, QL	Requires 30-day trial of generic SSRI/SNRI in last 180 days. QL of 30 per month
ISENTRESS	3				
isoniazid			1		
ISOPTO CARPINE	4	pilocarpine ophthalmic	1		
ISORDIL	4	isosorbide dinitrate	1		
JANUMET	3				
JANUMET XR	3				
JANUVIA	3				
JARDIANCE	3				
JENTADUETO	4			MN	Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza
JINTELI			1		
KALETRA	3				
KAPVAY	4	clonidine ext-rel	1	QL	QL of 120 tablets per month

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
KAZANO	4			MN	Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza
KEFLEX	4	cephalexin	1		
KEPPRA	4	levetiracetam	1		
KEPPRA XR	4	levetiracetam	1		
ketoconazole tabs			1		
ketoprofen			1		
KHEDEZLA	4			ST, QL	Requires 30-day trial of generic SNRI in last 180 days. QL of 31 per month.
KINERET	6			MN	See specialty drug list for further information.
KLONOPIN	4	clonazepam	1		
KOMBIGLYZE XR	3				
labetalol			1		
lactulose			1		
LAMICTAL CHEW TABS	4	lamotrigine	1		
LAMICTAL TABS	4	lamotrigine	1		
LAMICTAL XR	4	lamotrigine ext-rel	1		
LAMISIL TABS	4	terbinafine	1		
LANOXIN	4	digoxin	1		
lansoprazole delayed-rel OTC			1	QL	OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month.
lansoprazole delayed-rel (Rx)			1	QL	PA required for more than once-daily dosing
LANTUS (ALL FORMS)	3				
LASIX	4	furosemide	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
LATUDA	4			ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone ziprasidone or Seroquel XR in the last 365 days
LAZANDA	4			PA, QL. QL is 8 bottles at retail per month.	Coverage provided for members 18 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain
LESCOL	4	fluvastatin	1	MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin
LESCOL XL	4	fluvastatin ext-rel	1	MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin
LETAIRIS	5			PA	See specialty drug list for further information.
LEVAQUIN	4	levofloxacin	1		
LEVEMIR	4			MN	Alternative that does not require PA for medical necessity is Lantus.
LEVITRA	4			See limitations	Check member drug benefit for coverage of oral erectile dysfunction drugs
LEVORA			1		
LEVOXYL			1		
LEVSIN	4	hyoscyamine	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
LEXAPRO	4	escitalopram	1		
LEXIVA	3				
lidocaine viscous			1		
LINZESS	3				
LIPITOR	4	atorvastatin	1	MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin
LIPOFEN	4			ST	Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix)
LIPTRUZET	4			MN	Alternative that does not require PA for medical necessity is atorvastatin
lithium carbonate			1		
LITHOBID	4	lithium	1		
LIVALO	4			MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin
LOFIBRA	4	fenofibrate	1	ST	Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) to align with Tricor, TriGlide, Trilipix
LOMOTIL	4	diphenoxylate/ atropine	1		
loperamide			1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
LOPID	4	gemfibrozil	1		
LOPRESSOR	4	metoprolol	1		
LOPROX GEL, LOTION	4	ciclopirox topical	1		
loratadine OTC			1		OTC preparation available at Tier 1 copayment with prescription for OTC formulation
loratadine-D OTC			1		OTC preparation available at Tier 1 copayment with prescription for OTC formulation
LOTEMAX	3				
LOTENSIN	4	benazepril	1		
LOTENSIN HCT	4	benazepril/HCT	1		
LOTREL	4	amlodipine/ benazepril	1		
LOTRONEX	4	alosetron	1	PA	Coverage provided to female members with severe diarrhea-predominant irritable bowel syndrome (IBS) who have chronic IBS symptoms (generally lasting six months or longer), had anatomic or biochemical abnormalities of the gastrointestinal tract excluded, and not responded adequately to conventional therapy. PA is required for both brand and generic formulations.
LOVAZA	5	omega-3-acid ethyl esters	1	PA	Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA-approved therapy to lower triglycerides along with diet. PA is required for both brand and generic formulations.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
LOVENOX	6	enoxaparin	6	QL, PA	QL of maximum 35-day supply at retail pharmacy. Additional quantities require PA through preferred specialty pharmacy.
LOW-OGESTREL			1		
LUMIGAN 0.01%	4			MN	Alternatives that do not require PA for medical necessity are latanoprost, travoprost, Travatan Z, Zioptan
LUNESTA	4	eszopiclone	1	MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order.
LURIDE	4	sodium fluoride	1		
LURIDE LOZI-TABS	4	sodium fluoride	1		
LYRICA	4			QL	QL for doses ≤ 200 mg, 90 caps per 30 days. QL for doses ≥ 225 mg, 60 caps per 30 days. Lyrica solution QL 900 mL per 30 days
MACRODANTIN	4	nitrofurantoin	1		
MALARONE	4	atovaquone/ proguanil	1		
MAVIK	4	trandolapril	1		
MAXALT/MAXALT-MLT	4	rizatriptan	1	QL	QL of 8 tabs per month. Additional quantities require PA.
MAXITROL	4	neomycin/ polymixin B/ dexamethasone ophthalmic	1		
MAXZIDE	4	triamterene/HCT	1		
MENEST	4				
MESTINON 60 mg	4	pyridostigmine	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
MESTINON SYRUP	3				
MESTINON TIMESPAN	4	pyridostigmine ext-rel	1		
METADATE CD (10, 30, 40, 50, 60 mg)	4	methylphenidate ext-rel	1	QL	Quantity Limit: 10mg-30mg: 60 per month 40mg-60mg: 30 per month
METAGLIP	4				
methazolamide			1		
methotrexate 2.5 mg, oral			1		
methyldopa			1		
METROGEL TOPICAL	4	metronidazole topical	1		
METROGEL VAG 0.75% GEL	4	metronidazole vaginal	1		
MEVACOR	4	lovastatin	1	MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin
MIACALCIN SPRAY	4	calcitonin-salmon	1	QL	QL of 2 units per month
MICARDIS	4	telmisartan	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
MICARDIS HCT	4	telmisartan HCT	1	MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
MICRO-K	4	potassium chloride	1		
MIGRANAL NASAL	4	dihydroergotamine nasal	1	QL	QL of 8 units per month
MINIPRESS	4	prazosin	1		
MINOCIN	4	minocycline	1		
minocycline ext-rel			1	ST	Coverage requires that members be 12 years or older and must have tried at least 30 days of a generic immediate-release minocycline and a 30-day supply of one of these generics (doxycycline, erythromycin or tetracycline) within the previous 365 days
MIRAPEX	4	pramipexole	1		
MIRCETTE	4	desogestrel/ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
MODICON	4	norethindrone/ ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
MONODOX	4	doxycycline monohydrate	1	PA	Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
MONOVISC	6			MN	See specialty drug list for further information.
morphine sulfate immediate-release			1	QL	QL of 150 tabs per month
morphine suppository			1		
MOVIPREP	3				
MOXEZA	5				
MS CONTIN	4	morphine sulfate ext-rel	1	QL	QL of 90 tabs per month
MYAMBUTOL	4	ethambutol	1		
MYRBETRIQ	4			MN	Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel, trospium, trospium ext-rel, Gelnique, Vesicare
MYFORTIC	6	mycophenolic acid	2		
MYSOLINE	4	primidone	1		
nabumetone			1		
NAMENDA SOLUTION	4	memantine	1		
NAMENDA XR	4				
NAPRELAN	4	naproxen sodium ext-rel	1	MN	Alternatives that do not require PA for medical necessity are generic NSAIDs
NAPROSYN	4	naproxen	1		
NARDIL	4	phenelzine	1		
NASACORT AQ	4	triamcinolone nasal	1	MN, QL	Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month
NASONEX	3			QL	QL of 2 inhalers per month

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
NATESTO	4			MN	If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options
NEORAL	6	cyclosporine, modified	2		
NEOSPORIN	4	bacitracin/neomycin/ polymyxin B topical	1		
NESINA	4			MN	Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza
NEURONTIN	4	gabapentin	1		
NEXIUM (Rx)	4	esomeprazole magnesium	2	MN, ST, QL	PA for medical necessity requires trial/failure of both Nexium 24HR (OTC) and a generic PPI (lansoprazole, omeprazole, rabeprazole or pantoprazole). QL of 31 caps or granule packets per month. PA required for more than once-daily dosing.
NEXIUM 24HR (OTC)	1			QL	OTC preparation available at Tier 1 copayment with prescription. QL of 84 per month.
NIASPAN	4	niacin	1		
nicotine transdermal patches OTC			1		Check member drug benefit for coverage of smoking cessation drugs. OTC preparation available at Tier 1 copayment with prescription.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
NICOTROL INHALER	$0			PA, QL	Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials Limit of 30-day supply for each prescription; maximum therapy of 180 days per each 365 period.
NICOTROL NASAL SPRAY	$0			PA, QL	Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials Limit of 30-day supply for each prescription; maximum therapy of 180 days per each 365 period.
NIMOTOP	4	nimodipine	1		
NITRO-DUR	4	nitroglycerin transdermal	1		
nitroglycerin transdermal patches			1		
NITROSTAT	4				
NORCO	4	hydrocodone/APAP	1	QL	Max 3 grams acetaminophen (APAP) per day
NORDITROPIN	5			PA	See specialty drug list for further information.
NORPRAMIN	4	desipramine	1		
NORVASC	4	amlodipine	1		
NORVIR	3				
NOVOFINE	3				
NOVOLIN (ALL FORMS)	3				
NOVOLOG (ALL FORMS)	3				

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
NOXAFIL	4				
NUTROPIN AQ	6			MN	See specialty drug list for further information.
NUVARING	3				Packaged as 90-day supply for 2 times the applicable copayment
NUVIGIL	4			PA, QL	Coverage provided for members with a diagnosis of narcolepsy, multiple sclerosis-related fatigue, persistent sleepiness due to obstructive sleep apnea refractory to traditional treatments (i.e., CPAP, etc.) and sleepiness associated with diagnosed shift work sleep disorder
nystatin			1		
OCUFLOX	4	ofloxacin ophthalmic	1		
ofloxacin otic			1		
OLUX-E FOAM	4	clobetasol topical	1	MN	Alternative that does not require PA for medical necessity is clobetasol propionate foam 0.05%
omeprazole caps (Rx)			1	QL	QL of 31-caps-per month. PA required for more than once-daily dosing.
omeprazole OTC			1	QL	OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month.
OMNARIS	4			MN, QL	Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month.
OMNITROPE	6			MN	See specialty drug list for further information.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
OMTRYG	4			PA	Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA-approved therapy to lower triglycerides along with diet
ONETOUCH kits and test strips	3				
ONGLYZA	3				
ONMEL	4			PA	Coverage provided to members who have diagnosis of onychomycosis of the toenail.
OPSUMIT	5			PA	See specialty drug list for further information.
ORENCIA SQ	6			MN	See specialty drug list for further information.
ORTHO-CYCLEN	4	norgestimate/ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
ORTHO EVRA	4	norelgestromin/ethinyl estradiol transdermal	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
ORTHO MICRONOR	4	norethindrone	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
ORTHO TRI-CYCLEN	4	norgestimate/ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ORTHO TRI-CYCLEN LO	4	norgestimate/ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
ORTHO-NOVUM	4	norethindrone/ ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
ORTHOVISC	6			MN	See specialty drug list for further information.
OSENI	4			MN	Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza
OTEZLA	6			MN	See specialty drug list for further information.
OVIDE	4	malathion	1		
OXANDRIN	4			PA	Coverage provided for adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma.
oxazepam			1		
oxybutynin			1		
OXYCONTIN	3			QL	QL of 120 tabs per month. Additional quantities require PA.
OXYTROL	4			MN	Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel, trospium, trospium ext-rel, Gelnique, Vesicare
PAMELOR	4	nortriptyline	1		
PANCREAZE	3				

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
PANRETIN	4				
PATADAY	3				
PATANASE	4	olopatadine	1	QL	QL of 1 inhaler per month
pantoprazole			1	QL	QL of 31 caps per month. PA required for more than once-daily dosing.
PARLODEL	4	bromocriptine	1		
PARNATE	4	tranylcypromine	1		
PAXIL	4	paroxetine	1		
PAXIL CR	4	paroxetine	1		
PCE	4				
PEGASYS	5			PA	See specialty drug list for further information.
PEG-INTRON	6			PA	See specialty drug list for further information.
penicillin VK			1		
PENNSAID 2%	4			MN	Alternatives that do not require PA for medical necessity are generic NSAIDs
PEPCID (Rx)	4	famotidine	1		
PERCOCET	4	oxycodone/APAP	1	QL	
PERIDEX	4	chlorhexidine oropharyngeal	1		
perphenazine			1		
PERSANTINE	4	dipyridamole	1		
phenobarbital			1		
PHOSLO	4	calcium acetate	1		
PICATO	5				
pindolol			1		
PLAQUENIL	4	hydroxychloroquine sulfate	1		
PLAVIX	4	clopidogrel	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
PLEGRIDY	6			MN	See specialty drug list for further information.
POLYTRIM	4	polymyxin B/trimethoprim ophthalmic	1		
potassium chloride ext-rel, liquid			1		
PRADAXA	4				
PRANDIN	4	repaglinide	1		
PRAVACHOL	4	pravastatin	1	MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin
PRECOSE	4	acarbose	1		
PRED FORTE	4	prednisone acetate ophthalmic	1		
PRED MILD	3				
prednisolone acetate 1%			1		
prednisone			1		
PREFERAOB VITAMINS	3				
PRELONE	4	prednisolone	1		
PREMARIN	3				
PREMPHASE	3				
PREMPRO	3				
PREVACID (Rx)	4	lansoprazole	1	ST, QL	Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing.
PREVACID 24HR OTC	1	lansoprazole	1	QL	OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
PREZISTA	3				
PRILOSEC (Rx)	4	omeprazole	1	ST, QL	Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing.
PRILOSEC OTC	1	omeprazole	1	QL	OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month.
PRISTIQ	4			ST, QL	Requires 30-day trial of generic SNRI in last 180 days. QL of 31 per month.
PROAIR HFA, Respiclick	3			QL	QL of 2 inhalers per month
probenecid			1		
PROCARDIA XL	4	nifedipine	1		
prochlorperazine			1		
PROCRIT	5			PA	See specialty drug list for further information.
PROGRAF	6	tacrolimus	2		
promethazine			1		
promethazine w/ codeine			1		
promethazine w/ dextromethorphan			1		
propranolol tabs			1		
propylthiouracil			1		
PROSCAR	4	finasteride	1	PA	Coverage provided for the treatment of symptomatic benign prostatic hypertrophy in males over age 40. PA is required for both brand and generic formulations.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
PROTONIX	4	pantoprazole	1	ST, QL	Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole or OTC PPI. PA required for more than once-daily dosing.
PROTOPIC	4	tacrolimus topical	1		Coverage for 2 years of age and up for 0.03%, 16 years and up for 0.1%. Outside of these ages, call BlueChoice at 800-950-5387.
PROVENTIL HFA	4			QL	QL of 2 inhalers per month
PROVERA	4	medroxyprogesterone	1		
PROVIGIL	4	modafinil	1	PA, QL	Coverage requires members try and fail at least a 30-day trial of Nuvigil in the last 365 days and meet PA requirement for indications. QL of 60 per month.
PROZAC	5	fluoxetine	1		
PROZAC WEEKLY	4	fluoxetine	1	QL	QL of 4 per month at retail or 12 per 3 months by mail order
PULMICORT FLEXHALER	4			QL	QL of 2 inhalers per month
PULMICORT RESPULES	4	budesonide inhaled	1	QL	QL of 1 box per month
pyrazinamide			1		
PYRIDIUM	4	phenazopyridine	1		
QNASL	4			MN, QL	Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month at retail or 3 inhalers per 90 days by mail order.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
QUALAQUIN	4	quinine sulfate	1	QL, PA	QL of 42 caps per year. Additional quantities require PA.
QUESTRAN/QUESTRAN-LIGHT	4	cholestyramine	1		
QUILLICHEW ER	4			QL	Quantity Limit: 20mg-30mg: 60 per month 40mg: 30 per month
QUILLIVANT XR	4			QL	QL of 360 mL per month
QVAR	3			QL	QL of 2 inhalers per month
ramipril			1		
RAPAMUNE	6	sirolimus	2		
RAYOS	4			MN	Alternative that does not require PA for medical necessity is prednisone
RAZADYNE	4	galantamine	1		
REBIF	5			PA	See specialty drug list for further information.
REGLAN TABS	4	metoclopramide	1		
RELPAX	4			QL,	QL of 8 tabs per month, all strengths. Additional quantities require PA.
REMERON	4	mirtazapine	1		
REMERON SOLTAB	4	mirtazapine	1		
REMICADE	6			MN	See specialty drug list for further information.
RENAGEL	4				
RENVELA	3				
REPATHA	5			PA	See specialty drug list for further information.
REQUIP	4	ropinirole	1		
REQUIP XL	4	ropinirole ext-rel	1		
RESCRIPTOR	3				
RESTORIL	4	temazepam	1	QL	QL of 31 per month

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
RETIN-A CREAM, GEL	4	tretinoin topical	1	ST	Coverage up to age 25 for acne. If over 25 yrs, PA required.
RETIN-A MICRO GEL	4	tretinoin topical	1	ST	Coverage up to age 25 for acne. If over 25 yrs, PA required.
RETROVIR	4	zidovudine	1		
REYATAZ	3				
RHINOCORT AQ	4	budesonide nasal	1	MN, QL	Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 2 inhalers per month.
RIFADIN	4	rifampin	1		
RIOMET	4			MN	Alternatives that do not require PA for medical necessity are metformin, metformin ext-rel
RISPERDAL/ RISPERDAL M	4	risperidone	1	ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone ziprasidone or Seroquel XR in the last 365 days
RITALIN	4	methylphenidate	1	QL	QL of 90 per month
RITALIN LA	4	methylphenidate ext-rel	1	QL	Quantity Limit: 10mg-30mg:60 per month 40mg-60mg: 30 per month
RITUXAN	6			MN	See specialty drug list for further information.
ROBAXIN	4	methocarbamol	1		
ROCALTROL	4	calcitriol	1		
ROWASA ENEMA	4	mesalamine rectal	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ROXICODONE	4	oxycodone	1	QL	QL of 90 per month
ROZEREM	3			QL	QL of 31 per month at retail or 93 per 3 months by mail order
RYTHMOL	4	propafenone	1		
RYTHMOL SR	4	propafenone ext-rel	1		
SAIZEN	6			MN	See specialty drug list for further information.
SANCUSO	4			QL, PA	QL of 2 patches per month, all strengths. Additional quantities require PA.
SANDIMMUNE	6	cyclosporine	2		
SAPHRIS	4			ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days
SAVELLA	3			QL	QL of 62 caps per month
SEASONIQUE	4	levonorgestrel/ ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials Packaged as 90-day supply for 2 times the applicable copayment
selegiline tabs			1		
selenium sulfide shampoo 2.5%			1		
SELZENTRY	3				
SENSIPAR	3				
SEREVENT DISKUS	3			QL	QL of 1 inhaler per month

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
SEROQUEL	4	quetiapine	1	ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days
SEROQUEL XR	3				
SILENOR	4			MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order.
SILVADENE	4	silver sulfadiazine topical	1		
SIMCOR	3				
SIMPONI/ARIA	6			MN	See specialty drug list for further information.
SINEMET	4	carbidopa/levodopa	1		
SINEMET CR	4	carbidopa/levodopa ext-rel	1		
SINGULAIR	4	montelukast	1		
SOLODYN	5	minocycline ext-rel	1	ST	Coverage requires that members be 12 years or older and must have tried at least 30 days of a generic immediate-release minocycline and a 30-day supply of one of these generics (doxycycline, erythromycin or tetracycline) within the previous 365 days. ST is required for brand and generic.
SOMA	4	carisoprodol	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
SONATA	4	zaleplon	1	MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 tabs per month at retail or 93 per 3 months by mail order.
SORIATANE CAPS	4	acitretin	1	PA	PA for treatment of severe psoriasis in adults
SOVALDI	6			MN	Non-Preferred product for Genotype 1 and Genotype 4 (chronic HCV only) See specialty drug list for further information.
SPIRIVA HANDIHALER	3			QL	QL of 1 inhaler per month
SPIRIVA RESPIMAT	3			QL	QL of 1 inhaler per month
SPORANOX CAPS	4	itraconazole	1	PA, QL	Coverage provided to members for treatment of onychomycosis. QL of 31 caps per month. Max 3 months of therapy per year. PA is required for both brand and generic formulations.
SPORANOX SOLUTION	4			PA, QL	Coverage provided for members for treatment of oropharyngeal and esophageal candidiasis. QL of 600mL per month, with max 1800mL per year.
SPRIX	4			MN	Alternatives that do not require PA for medical necessity are generic NSAIDs
STAXYN	4			See limitations	Check member drug benefit for coverage of oral erectile dysfunction drugs
STELARA	6			MN	See specialty drug list for further information.
STRATTERA	3			QL	Quantity Limit: 10mg-40mg: 60 per month 60mg-100mg: 30 per month

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
SUBOXONE sublingual film	3			PA, QL	Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program
SUBSYS	5			PA, QL QL is 120 doses per month.	Coverage provided for members 18 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain
sulfamethoxazole-trimethoprim			1		
SUMAVEL DOSEPRO	4			ST, QL	Coverage requires that members must have filled 14 days of generic sumatriptan injection in the last 180 days. QL of 6 per month. Additional quantities require PA.
SUPARTZ	5			PA	See specialty drug list for further information.
SUSTIVA	3				
SYMBICORT	3			QL	QL of 2 inhalers per month
SYMLIN PEN	4				
SYNJARDY	3				
SYNTHROID	4	levothyroxine	1		
SYNVISC/ONE	6			MN	See specialty drug list for further information.
TACLONEX	4	calcipotriene/ betamethasone	3		
TAMIFLU	4			QL	QL of 10 caps (1 blister pack) per year
tamoxifen			1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
TANZEUM	4			MN, QL	QL of 4 pens per month. Alternatives that do not require PA for medical necessity are Bydureon, Victoza
TAPAZOLE	4	methimazole	1		
TARGADOX	5			PA	Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review.
TARKA	4	trandolapril/ verapamil ext-rel	1		
TAZORAC	4			ST	Requires 30-day trial of generic tretinoin product in the last 365 days
TECFIDERA	5			PA	See specialty drug list for further information.
TEGRETOL	4	carbamazepine	1		
TEGRETOL XR	4	carbamazepine ext-rel	1		
TEKTURNA	4			MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
TEKTURNA HCT	4			MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
TEMOVATE	4	clobetasol topical	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
TENORMIN	4	atenolol	1		
terazosin			1		
terbutaline			1		
TESSALON	4	benzonatate	1		
TEST STRIPS (except ONETOUCH)	4			MN	Alternatives that do not require PA for medical necessity are ONETOUCH products
TESTIM	4	testosterone gel	1	MN	If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options. PA is required for both brand and generic formulations.
tetracycline			1		
TEVETEN	4			MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
TEVETEN HCT	4			MN	Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT
THEOCHRON	4	theophylline	1		
theophylline ext-rel (12 hr)			1		
thiothixene			1		
TIMOPTIC	4	timolol ophthalmic	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
TIROSINT	5				
TOBRADEX ST	3				
tobramycin-dexamethasone 0.3-0.1%			1		
TOBREX	4	tobramycin ophthalmic	1		
TOFRANIL	4	imipramine	1		
TOPAMAX	4	topiramate	1		
TOPROL XL	4	metoprolol succinate ext-rel	1		
TOUJEO	4			MN	Alternative that does not require PA for medical necessity is Lantus.
TOVIAZ	4			MN	Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel. trospium, trospium ext-rel, Gelnique, Vesicare
TRACLEER	5			PA	See specialty drug list for further information.
TRADJENTA	4			MN	Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza
TRAVATAN Z	3				
travoprost			1		
trazodone			1		
TREXIMET	5			QL	QL of 9 tabs per month. Additional quantities require PA.
triamcinolone crm 0.5%			1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
triamcinolone crm, lotion 0.025%			1		
triamcinolone crm, lotion, oint 0.1%			1		
triamcinolone paste			1		
TRIBENZOR	3				
TRICOR	4	fenofibrate	1	ST	Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix)
TRIGLIDE	4			ST	Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix)
trihexyphenidyl			1		
TRILEPTAL	4	oxcarbazepine	1		
TRILIPIX	4			ST	Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix)
trimethoprim			1		
TRI-NORINYL	4	norethindrone/ ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
TRIVORA			1		
TRIZIVIR	4	abacavir/lamivudine/ zidovudine	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
trospium			1		
trospium ext-rel			1		
TRULICITY	4			MN, QL	QL of 4 pens per month. Alternatives that do not require PA for medical necessity are Bydureon, Victoza
TRUSOPT	4	dorzolamide ophthalmic	1		
TRUVADA	3				
TWYNSTA	4	telmisartan/ amlodipine	1		
TYLENOL w/ CODEINE	4	acetaminophen/ codeine	1	QL	QL of 300 per month
TYSABRI	6			MN	See specialty drug list for further information.
ULORIC	4			ST	Coverage requires a 30-day trial of allopurinol in the past 180 days
ULTRAM	4	tramadol	1	QL	QL of 240 per month
ULTRAM ER	4	tramadol ext-rel	1	QL	QL of 30 per month
URECHOLINE	4	bethanechol	1		
URSO	4	ursodiol	1		
VALCYTE	4	valganciclovir	1		
VALIUM	4	diazepam	1		
VALTREX	4	valacyclovir	1	QL	QL of 42 caps of 500 mg per fill or 84 caps per month; QL of 31 caps of 1000 mg per month.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
VASCEPA	4			PA	Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA-approved therapy to lower triglycerides along with diet
VASERETIC	4	enalapril HCT	1		
VASOTEC	4	enalapril	1		
venlafaxine			1		
venlafaxine ext-rel			5	QL	QL of 31 of 37.5 mg, 75 mg, 150 mg. QL of 31 of 225 mg or use (31 of 150 mg + 31 of 75 mg) = 1 copayment.
VENTOLIN HFA	3			QL	QL of 2 inhalers per month
VERAMYST	4			MN, QL	Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month.
VERSACLOZ	4			ST	Requires 30-day trial of clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days
VESICARE	3				
VFEND	4	voriconazole	1		
VIAGRA	4			See limitations	Check member drug benefit for coverage of oral erectile dysfunction drugs
VIBRAMYCIN	4	doxycycline	1		
VICODIN ES	4	hydrocodone/APAP	1	QL	Max 3 grams acetaminophen (APAP) per day

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
VICTOZA	3				
VICTRELIS	6			PA	See specialty drug list for further information.
VIDEX EC	4	didanosine	1		
VIDEX SOLN	3				
VIEKIRA PAK	5			PA	Preferred product for Hepatitis C Genotype 1 See specialty drug list for further information.
VIGAMOX	3				
VIMPAT	5				
VIRACEPT	3				
VIRAMUNE	4	nevirapine	1		
VIRAMUNE XR	3	nevirapine ext-rel	1		
VIREAD	3				
VIROPTIC	4	trifluridine ophthalmic	1		
vitamin B-12 inj			1		
VIVELLE-DOT	4	estradiol transdermal	1		
VOGELXO	4	testosterone gel	1	MN	If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options. PA is required for both brand and generic formulations.
VYTORIN	4			MN	Alternative that does not require PA for medical necessity is atorvastatin.
VYVANSE	4			QL	Quantity Limit: 10mg-30mg: 60 per month 40mg-70mg: 30 per month
WELCHOL	3				
WELLBUTRIN	4	bupropion	1		
WELLBUTRIN SR	4	bupropion ext-rel	1		

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
WELLBUTRIN XL	4	bupropion ext-rel	1	QL	QL of 31 per month for 150 mg or 300 mg.
XALATAN	4	latanoprost	1		
XANAX	4	alprazolam	1		
XARELTO	3				
XARTEMIS XR	5			QL	Max 3 grams acetaminophen (APAP) per day
XELJANZ	6			MN	See specialty drug list for further information.
XELODA	6	capecitabine	2	PA	See specialty drug list for further information.
XIGDUO XR	3				
XYZAL	4	levocetirizine	1	ST	Coverage requires a trial of OTC non-sedating/mildly sedating antihistamine for 21 days in the last 12 months
YASMIN	4	drospirenone/ ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
YAZ	4	drospirenone/ ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
ZANTAC (Rx)	4	ranitidine	1		
ZARONTIN	4	ethosuximide	1		
ZAROXOLYN	4	metolazone	1		
ZEGERID	5	omeprazole/sodium bicarbonate	4	ST, QL	Requires step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole or OTC PPI. PA required for more than once-daily dosing. ST is required for brand and generic.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ZEGERID OTC	1	omeprazole/sodium bicarbonate	1	QL	OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month.
ZEMPLAR	4	paricalcitol	1		
ZERIT	4	stavudine	1		
ZESTORETIC	4	lisinopril HCT	1		
ZESTRIL	4	lisinopril	1		
ZETIA	4				
ZETONNA	4			MN, QL	Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex
ZIAGEN tabs	3	abacavir	1		
ZIAGEN SOLUTION	3				
ZIOPTAN	3				
ZIPSOR	4			MN	Alternatives that do not require PA for medical necessity are generic NSAIDs
ZITHROMAX	4	azithromycin	1		
ZOCOR	4	simvastatin	1	MN	Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin.
ZOFRAN	4	ondansetron	1	QL, PA	QL of 9 per month for 4 mg, 6 per month for 8 mg, 50 mL per month for solution. Additional quantities require PA.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ZOHYDRO ER	5			QL	Coverage provided for members with pain severe enough to require daily, around-the-clock, long-term treatment and for which alternative treatment options are inadequate. QL of 120 per month for 10, 15 and 20 mg. QL of 60 per month for 30, 40 and 50 mg.
ZOLOFT	4	sertraline	1		
ZOLPIMIST	4			MN, QL	Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 tabs per month at retail or 93 per 3 months by mail order.
ZOMACTON	6			MN	See specialty drug list for further information.
ZOMIG NASAL	4			QL	QL of 1 package (6 units) per month
ZOMIG/ZOMIG-ZMT	4	zolmitriptan	1	QL	QL of 6 per month. Additional quantities require PA.
ZONEGRAN	4	zonisamide	1		
ZORTRESS	4			QL	QL of 62 per month for 0.25 mg. QL of 124 for 0.5 mg and 0.75 mg.
ZORVOLEX	4			MN	Alternatives that do not require PA for medical necessity are generic NSAIDs
ZOVIA		ethynodiol/ethinyl estradiol	$0		Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials
ZOVIRAX CAPS, OINT, SUSP, TABS	4	acyclovir	1		
ZOVIRAX CREAM	4				

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Drug	Brand Tier	Generic Available	Generic Tier	Usage Guidelines	Limitations
ZUBSOLV	5			MN, QL	Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program. Alternatives that do not require PA for medical necessity are generic buprenorphine-naloxone sublingual tablets and Suboxone film.
ZUPLENZ	4			QL, PA	QL of 10 per month. Additional quantities require PA.
ZYLET	3				
ZYLOPRIM	4	allopurinol	1		
ZYMAXID	4	gatifloxacin ophthalmic	1		
ZYPREXA	4	olanzapine	1	ST	Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone ziprasidone or Seroquel XR in the last 365 days
ZYRTEC OTC	1	cetirizine	1		OTC preparation available at Tier 1 copayment with prescription
ZYRTEC-D OTC	1	cetirizine/ pseudoephedrine	1		OTC preparation available at Tier 1 copayment with prescription
ZYVOX	4	linezolid	1		

Health Care Reform Coverage

The Affordable Care Act (ACA) requires health insurance plans to cover certain drugs such as aspirin, female contraceptives, folic acid, iron supplements, oral fluoride agents, vaccines and tobacco cessation products at $0 (no charge.) **Covered OTC products require a prescription to have coverage under your pharmacy benefit.** These ACA benefits apply to most, but not all, employer groups. Check your plan documents or log into My Health Toolkit and use the Drug Coverage and Cost Tool.

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

MISCELLANEOUS
Aspirin: Coverage is for OTC generics only for members aged 12-79. Maximum of one dose per day of 81mg, 162 mg or 325mg tablets or capsules. No coverage for buffered aspirin, powders, suppositories or effervescent tablets.
Bowel Preparations for colonoscopy: Halflytely, Moviprep, Prepopik, Suprep (Only those aged 50-75 have $0 coverage)
Breast Cancer Prevention: We cover generic tamoxifen and raloxifene for females aged 35 and older.
Folic Acid: We cover prescription generics or OTC products for females only. Max one dose per day of 0.4 and 0.8mg strength. We do not cover OTC prenatal vitamins or combination products.
Iron Supplements: Oral liquid dosage forms on single-ingredient only. We cover OTC generics and brands for those up to age 1 only.
Oral Fluorides: We cover only single-ingredient prescription generics. There is a maximum daily dose limit. Only ages zero to 17 years old have $0 coverage.
Tobacco Cessation: We cover prescription products (bupropion 150mg, Chantix, Nicotrol nasal spray, Nicotrol inhaler) with prior authorization. We cover OTC products (nicotine patches, gum and lozenges) with prescription. Limit of 30-day supply for each prescription filled. Maximum therapy of 180 days per each 365 period.
Vitamin D: Only those aged 65 and older have $0 coverage. Includes OTC with prescription.

VACCINES	
DIPHTHERIA-TETANUS TOXOID & PERTUSSIS VACCINE	MEASLES, MUMPS & RUBELLA VIRUS VACCINES
DIPHTHERIA-TETANUS TOXOIDS (DT)	MENINGOCOCCAL
DIPHTHERIA, PERTUSSIS & TETANUS	PNEUMOCOCCAL
HAEMOPHILUS B POLYSACCHARIDE CONJUGATE	POLIO VACCINE
HEPATITIS A (INACTIVATED) - HEPATITIS B (RECOMB)	RECOMBIVAX HB
HEPATITIS A VACCINE	ROTAVIRUS VACCINE
HEPATITIS B VACCINE (RECOMB)	TETANUS TOXOID
HUMAN PAPILLOMAVIRUS (HPV)	TETANUS-DIPHTHERIA TOXOIDS (TD)
INFLUENZA	VARICELLA VIRUS VACCINE LIVE
MEASLES-MUMPS-RUBELLA-VARICELLA VIRUS VACCINE	ZOSTER VACCINE LIVE

FEMALE CONTRACEPTIVES
Oral Contraceptives
All generic oral contraceptives (birth control pills) are available at $0 if your plan has ACA benefits.
Other Female Contraceptives

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy

Cervical Cap: FEMCAP, PRENTIF, PRENTIF FITTING KIT
Diaphragms: OMNIFLEX DIAPHRAGM, ORTHO COIL SPRING KIT, ORTHO FLAT SPRING KIT, ORTHO FLEX, WIDE-SEAL
Emergency Contraception: ELLA, NEXT CHOICE
Female Condom: FC2 FEMALE CONDOM
Implantable Rod: NEXPLANON
Intrauterine Device (IUD): MIRENA, PARAGARD
Patch: XULANE
Shot/Injection: MEDROXYPROGESTERONE AC (generic Depo-Provera)
Spermicide: CONCEPTROL GEL ,GYNOL II GEL, ENCARE SUPPOSITORIES, SHUR-SEAL GEL, VCF VAGINAL CONTRACEPTIVE FILM, VCF VAGINAL FOAM
Sponge: TODAY SPONGE
Vaginal Contraceptive Ring: NUVARING

Legend

lower case	generic medication	QL	Quantity Limit
$0	See Health Care Reform section for information	PA	Prior Authorization Required
MN	Medical Necessity Prior Authorization	ST	Step Therapy